October 21, 2011

To: U.S. Department of Health and Human Services
File code: CMS-9982-P

From: Dolores Mitchell, The Massachusetts Group Insurance Commission

RE: **Comments on Proposed Federal Rule, Summary of Benefits Coverage (SBC), Federal Register Vol.76, No.162, August 22, 2011**

The Massachusetts Group Insurance Commission (GIC) is responsible for negotiating, contracting for and administering health insurance benefits for over 350,000 public employees, retirees and their family members through both fully-insured and self-insured plans. The GIC submits the following comments on the proposed Summary of Benefits Coverage (SBC) regulations:

We at the GIC are supportive of the intended purpose of the SBC regulations: to provide consumers with better information about health plan benefits and approximate costs. These regulations are a step in the right direction, but they fail to take into account the variability and complexity of a multi-employer purchaser such as the Commonwealth of Massachusetts and, we suspect, other states as well. The approach the GIC has taken over the years to communicate benefit and premium information is simpler than the proposed Summary of Benefits, and has been very successful. See attached example.

We have specific concerns in the following areas:

1.) Administrative Burden and Extra Costs

The GIC is a multi-employer purchaser, and premium contributions vary as explained in more detail below (see #2). As the GIC administers twelve separate employee/Non-Medicare health plans with six carriers and each plan has different benefits and premiums, the new requirements would mean that we (for self-insured plans) and our plans (for the insured plans) would be producing at a minimum twelve additional communications for state employees, each spanning six potential premium contribution arrangements. Even though the GIC's fully-insured and self-insured plans would be paying for printing costs and expending extra labor in carrying out the SBC mandate, these costs would be passed onto the GIC members and the Massachusetts taxpayers. Even if only twelve additional documents (one per plan) were required, the cost would amount to one third of our budget for major enrollment communications per year. With postal and printing costs rapidly rising, these will increase dramatically over time. Additionally, as outlined below, multiple versions would be needed, adding to these initial estimates.

The GIC already produces comprehensive Benefit Decision Guides to help members weigh their options as a new hire and at annual enrollment. These

communications provide a single document to enable members to compare their options and also provides information on other non-health benefits.

2) Premium Contribution Field

The template of the proposed Summary of Coverage includes the member's premium dollar amount (p.1 in the template). GIC members pay widely varying premiums due to the number of entities we cover. For active state employees alone, the premium amount depends on date of hire and whether they have individual or family coverage, which would require four sections in that box alone, or alternatively four distinct documents.

We understand the Summary of Benefits need not be provided to Medicare retirees, but do we have an obligation to send the SBCs to non-Medicare retirees? If this group is included in this new requirement; we would have to add another eight boxes – or eight distinct documents – to the SBC (individual or family, for each of four scenarios related to date of retirement), for a total of twelve state employee/Non-Medicare retiree premium boxes, or twelve distinct documents.

Additionally, each of the 35 municipalities (and growing) that provides health benefits through the GIC has its own premium contribution splits, which varies by individual and family premium and can also vary by union, date of hire, and type of plan, depending on the collective bargaining agreement.

Therefore, under the proposed regulations, we would be required to produce thousands of unique documents (twelve plans, each with members from the state plus up to 35 different municipalities; and within each plan and payor, up to twelve different contribution splits between members and their employers). Again, this would be another large expense passed onto the members and the taxpayers.

The GIC therefore recommends that this field instead contain the most common individual and family premium, with a notation indicating where (e.g. benefits office, other materials) members can locate their particular premium.

3) Provider Rates – In network - Impossibility of Calculating Some Expenses

The template includes out-of-pocket costs for common medical events. The GIC tiers both doctors and hospitals, so the member's out-of-pocket costs at participating providers would be dependent on which doctors and hospitals the member used. The GIC recommends that this field be changed to a range of dollars for "you pay" field.

Although we understand the Coverage Examples are intended to give comparable information for similar services, the examples are not sufficiently

defined. Since the charges for maternity can vary greatly depending upon the type of labor and delivery a woman undergoes, there could be a significant cost differential depending upon the complexity of the treatment. Similar issues apply to the other two types of services (treating breast cancer and managing diabetes). We ask that HHS specify the CPT-4 and ICD-9 codes it has in mind in order to assist plans and payors in preparing appropriate and comparable cost estimates. For the plan pays dollar amount, the amount the plan pays is in many cases contract-protected information and not available to us and varies widely based on the hospital and physician practice used. We ask that for this field that we be permitted to indicate that the plan pays the balance of costs, as opposed to any specific amount.

4) Provider rates – Non-Participating Provider common medical event examples

Out-of-network benefits are paid at 80% of reasonable and customary rates, which vary by health plan contract rates. The GIC recommends the use of a percentage instead of a dollar amount .

5.) Timing and Distribution Challenges

The GIC operates on a fiscal (July 1) year basis and with this the March 23 deadline poses many challenges, particularly to cover new hires whose coverage goes into effect June 1. Producing the minimum 12 documents in addition to our regular communications and handbooks, times multiple variations of the SBC for the fiscal year ending June 30 in addition to the one beginning July 1 would be monumental. The GIC recommends that the SBC requirement be pushed to the next plan year beginning after September 23, 2012.

6.) Glossary

In some cases, the terminology of the SBC glossary is different from the terminology used by the GIC and its plans, and therefore it would add to confusion rather than facilitating the intended clarity. We request the ability if necessary to modify the definitions in the glossary to conform with state law and our health plan contracts.

7.) Requirement to Mail to All Insureds, Even if Not in Same Household

This requirement will create a large cost and administrative burden for the GIC, because the GIC does not maintain addresses of all family members and our IT system has no capacity to maintain multiple addresses per insured family. The GIC recommends that the requirement be changed to mailing to the insured's household.

8.) Culturally and Linguistically Appropriate Notices

Does this requirement mean that the GIC must produce each SBC in multiple different languages? The costs and logistics of matching names with languages spoken would be prohibitive. Our own attempts to provide multiple language versions of our plan documents have met with very limited interest.

Thank you for the opportunity to comment on the proposed rule. We appreciate your consideration of our comments, and we thank you for your efforts in promoting transparency for health insurance consumers.